STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL096-271	B. WING		01/29	: 9/2019
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	•	
1606 SALEM CHURCH ROAD						
WINSTON			ORO, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 000 II	NITIAL COMMENT	S	V 000			
2 (i	9, 2019. The com intake #NC001461	was completed on January plaint was substantiated 77). A deficiency was cited.				
С	ategory: 10A NCA	.C 27G .5600C Supervised h Developmental Disabilities.				
V 291 2	7G .5603 Supervis	sed Living - Operations	V 291			
(a s d oo the position of the	ix clients when the levelopmental disa on June 15, 2001, a nan six clients at the provide services at censed capacity. b) Service Coordination of the profession reatment/habilitation of the provided the opportulationship with her facility. Reports annually to the pare regally responsible personation of the facility. Reports annually to the pare regally responsible personation of the facility of the pare regally responsible personation of the facility. Reports annually to the pare regally responsible personation of the facility of the pare regally responsible personation. The facilities shall be denclusion. Choices	OPERATIONS illity shall serve no more than clients have mental illness or bilities. Any facility licensed and providing services to more lat time, may continue to no more than the facility's nation. Coordination shall be not the facility operator and the als who are responsible for an or case management. The Family or Legally note and the facility and visits outside a shall be submitted at least and of a minor resident, or the person of an adult resident. Writing or take the form of a setting individual goals. The setting individual goals are shall have as based on her/his choices, ment/habilitation plan. The setting individual when the court avolved or when health or				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-271	B. WING			C 29/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u>.</u>		
I WINSTON			EM CHURCI DRO, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 291	Continued From pa	ge 1	V 291				
	safety issues becon	ne a primary concern.					
	facility failed to main facility operator and responsible for the cone of three audited. Review on 12/20/18 revealed: -18 year old maleAdmission date of -Diagnoses of Mode Expressive languag Defiant Disorder, Collingairment. Review on 12/20/18 dated 8/18/18 revealed: -He required assists setting to assist with gaining independent -He relied on profesiminmal socialization -He attends a school loss and has demondeveloping socialization -He	views and interviews, the ntain coordination between the I the professionals who are client's treatment, affecting d clients (#1). The findings are: 3 of client #1's record 1/16/18. erate Intellectual Disability, ge Disorder, Oppositional erebral Palsy, and Hearing 3 of Individual Support Plan aled: ance within group home in skill development towards are. assional supports due to an skills. but for individuals with hearing instrated progression with ation skills at the program. 3 of sign in sheet for school cented tardiness between the					
	Interview on 12/20/	18 with School Director					

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ZEBT11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
			A. BOILDING.		- с		
		MHL096-271	B. WING	·		9/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE			
WINSTO	N		EM CHURCH DRO, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 291	-Client #1 arrived o and no communica regarding any incid -Client #1 has arrive odorShe was not aware returned from Client concernsShe has not had concerns has not had concerns of the representatives from the latest of t	to school "almost every day." ne day to school with bruising tion was made to school ents prior to being dropped off. ed to school with strong body e of any communication being at #1's home regarding school ommunication with any m Client #1's home. 18 with School Social Worker completed homework graments were detailed as ts" designed to address h as telling time on a clock and communication by Client #1's diness. en shared with Care cational Assistant on 1/18/19 completed homework. ded spelling, addition, and school with strong body odor. ss was excessive. et with any representatives me regarding concerns. en addressed with legal	V 291				
	Interview with Schorevealed:	ool Principal on 1/18/19					

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ZEBT11 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
		MHL096-271	B. WING		01/2	9/2019
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
WINSTO	N		EM CHURCH			
			ORO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 3	V 291			
	last 3 months. Freq disruption upon arri -Letters regarding of Client #1's group how with no response. -Client #1 arrived to not communicated -There has been not home or provider re	concerns have been mailed to ome and to Case Manager, o school with bruising that was by group home prior. o contact from Client #1's egarding concerns.				
	Interview on 12/20/18 with Staff #1 revealed: -He had been employed as House Manager for 1 monthHe has worked with Client #1 on increasing independenceHe communicated with Client #1 through gesturesAll efforts made to assist Client #1 in arriving to school on timeHe has had no contact with school personnel regarding concerns of Client #1.					
	-He had been empl 11/06/18He was responsibl responsibilities of C-He has "sometime when dropping Clie arrives at 8:00amHe has not had copersonnel regarding Interview on 1/29/19 revealed: -She had 1 converse with Care Coordina Client #1's school.	18 with Staff #4 revealed: oyed with facility since e for AM transportation client #1. s run over a few minutes" nt #1 at school but "generally" mmunication with school g concerns with Client #1. 9 with Qualified Professional cation around November, 2018 tor regarding concerns with Care Coordinator stated and not completing homework				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED	
		MHL096-271	B. WING		01/2	; 9/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WINSTO	N		EM CHURCH			
			ORO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 4	V 291			
	since been address	er knowledge, concerns had sed after discussing with staff. 9 with Clinical Services				
		ommunication with outside concerns are addressed.				

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